August 20, 2019

Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

RE: WC Docket No. 18-213 - Promoting Telehealth for Low-Income Consumers (FCC Connected Care Pilot)

Dear Commission,

On behalf of the Center for Connected Health Policy (CCHP), I am submitting the following comments on the Federal Communications Commission's (FCC) solicitation for comments regarding a proposed pilot to increase health services and access via telecommunications technology. CCHP is the federally designated national telehealth policy resource center. In that capacity, it provides technical assistance to state and federal policymakers, health systems, providers, national organizations and the general public on telehealth policy. CCHP also conducts analyses and research on telehealth policy. CCHP is a program under the Public Health Institute. We thank you for this opportunity to comment.
CCHP applauds the intention of the proposed Connected Care Pilot to provide connected care services over broadband for low income Americans and veterans. Many studies show telehealth's utility to facilitate improved health outcomes and reduce health care costs, both stated goals of the proposed pilot. As the federally designated telehealth policy resource center, our comments will be solely restricted to the policy issues and questions the notice of proposed rulemaking raised in regards to this pilot.

Limitations of Proposed Connected Care Pilot Based on Funding
As the Commission is aware, robust connectivity is necessary in the use of telehealth and can be difficult and expensive to obtain in rural areas. Due to this expense, the $100 million proposed for this pilot may not be adequate to cover the approximate twenty projects the FCC plans to fund with an 85% discount for broadband services and equipment. Because connectivity in the home setting can vary widely, funding for networking equipment in the homes may be necessary for patients to have the capability to connect. If there is no current connectivity, this would need to be built out which could quickly deplete funds.
Additionally, if services are to take place in patients' homes, it may be logistically difficult to ensure that when patients in a pilot may be widespread and not located in a single area.
CCHP is concerned that, as proposed, the pilot would not fund the actual telehealth equipment used by the patients in their homes. Relying on providers to fund this

equipment through other avenues (such as other grants) may act as a deterrent for some otherwise eligible providers to participate, especially those who serve low income communities, whom this pilot seeks to target.

In addition to the equipment purchased, upkeep and training in its use is also important. CCHP suggests that funds in the program also be allowed to be spent on any updates, especially if software is involved, and end user training and support. Patients and/or caregivers must be given sufficient support and training on how to use the equipment properly, but more importantly, to establish a comfort level for them to encourage the use of the equipment.

Finally, a stated purpose of the pilot is to gather data on participants' progress towards achieving the pilot's goals. The resources and staff time involved in aggregating, analyzing and reporting data can be quite significant, yet no funding is provided for administrative support. CCHP suggests re-evaluating the decision not to provide administrative support to the pilot participants, as this will place a significant burden on the pilot participants serving low-income and veteran populations, who are often already strapped with workforce shortages.

Policy Considerations

The definition of "connected care" in the pilot as a subset of telehealth that is focused on delivering remote medical, diagnostic and treatment-related services directly to patients outside of traditional brick and mortar facilities, is broad enough to include all three major telehealth modalities (live video, store and forward and remote patient monitoring). However, as mentioned in the notice of proposed rulemaking, certain reimbursement barriers may limit use of some of these telehealth application, especially to the home. For example, Medicare currently only reimburses certain services delivered via live video when the patient is located in a rural health professional shortage area or non-metropolitan statistical area, and in certain types of healthcare facilities, prohibiting reimbursement for services delivered to the home. Although there are exceptions for the home in the case of end-stage renal disease related visits and for treating substance use disorders or co-occurring mental health disorders. Additionally, federally qualified health centers and rural health centers are not eligible distant site providers for the services, and both would be eligible under the FCC's notice of proposed rulemaking for this pilot.

While non-face-to-face chronic care management and remote physiological monitoring is reimbursed under Medicare (as separate from telehealth), there are only a few eligible codes, and CMS is still expected to issue guidance (per the 2019 Finalized Physician Fee Schedule) to help practitioners and stakeholders understand the codes' elements including

scope of service requirements and code descriptors, including the modalities that fall under the term. The FCC may want to coordinate with CMS on the guidance and structure its pilot with this guidance in mind. On the state level, only 21 state Medicaid programs reimburse for some form of remote patient monitoring (RPM). Typically, there are also caveats included in those RPM policies such as only reimbursing for specific chronic conditions. Reimbursement from private insurers can be even murkier and uncertain. Most private payers will not disclose their telehealth reimbursement policies, viewing it as proprietary information, so it is difficult to ascertain the exact details on a plan's reimbursement policy. There are also varying laws among the states on the obligations of private payers to reimburse for telehealth services. Depending on how and where the FCC pilot takes place, it may not be sustainable if future funds to support the program are expected to come from either Medicaid or private payers.

Use of funds to support projects seeking to treat substance use disorder was mentioned at several points in the notice of proposed rulemaking. The FCC should be aware of limitations on prescribing controlled substances commonly used to treat SUD through medication assisted treatment (MAT). Currently, a patient must first have an in-person exam or fall under one of several exceptions within the definition of the practice of telemedicine under federal law. The most common exception is when the patient is physically located in a hospital or clinic registered with the DEA. The home would not be an acceptable location for a patient to be prescribed a controlled substance through telemedicine. The DEA is required to create a special registration to provide an exception to this requirement, however they have not yet released their proposed plans for such a rule.

Telehealth Resource Centers

CCHP supports the proposal that participants be encouraged to partner with their regional telehealth resource center (TRC) for advice on their proposed project and equipment selection. The TRCs are federally funded to provide technical assistance to community health centers and others on telehealth. The TRCs are agnostic in their advice and will be able to provide unbiased information to pilot participants. CCHP does not believe that funding should be limited to the TRCs or Centers of Excellence, as many of these entities do not provide direct patient services.

Extra Points for HPSAs and Medically Underserved Areas (MUAs)

The notice of proposed rulemaking suggests awarding extra points for applicants serving patients located in five or more HPSAs or MUAs as designated by HRSA. CCHP encourages the FCC to explicitly state that both (either/or) of the designations would allow for the extra points, in order to ensure that it is not later limited to only one. Both designations

identify populations with high health professional shortages and/or high unmet needs for health services, using different methodologies, and therefore it is important that both are options for applicants wanting to qualify for the extra points.

CCHP hopes these brief comments provide useful feedback for the proposed pilot. We are ready to answer any questions you may have. Please feel free to contact us at meik@cchpca.org or 877-707-7172.

Respectfully,

Mei Wa Kwong
Executive Director